Ontario not acting on calls to improve infection control in long-term care facilities as COVID-19 second wave looms

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This article was published more than 6 months ago. Some information in it may no longer be current.

A body on a guerney is taken out of the Eatonville Care Centre in Toronto, on April 14 2020.

FRED LUM/THE GLOBE AND MAIL

The Ontario government has not acted on recommendations from senior infectious disease experts to build infection prevention and control measures inside the province's long-term care facilities, raising concerns that the system remains vulnerable to outbreaks of COVID-19 as a second wave appears imminent.

A group of specialists advised the government in June that the long-term care sector must overhaul its infection control measures to be more in line with what hospitals do. But three months later, none of the group's recommendations have been implemented.

A draft copy of their proposal, obtained by The Globe and Mail, calls for the government to hire infection-control staff for long-term care facilities, at a ratio of one specialist per 200 beds at nursing homes and 250 beds in retirement homes. Those individuals would be trained and managed by the specialized doctors based at nearby acute-care hospitals, creating a "hub and spoke" model.

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Jeff Powis, the medical director of infection prevention and control at Toronto's Michael Garron Hospital and one of many doctors who contributed to the plan, said the delay is especially worrisome because it will take weeks – or months – to recruit and train staff and implement the proper protocols.

"We should have been doing this work well before now," Dr. Powis said. "The first thing we should have done when we saw ... decreasing numbers of long-term care outbreaks [in the summer] is sort out how we were going to do better during the second wave."

The situation is a reminder of the early days of COVID-19. A Globe and Mail investigation found that experts recognized the threat in February even though government officials insisted the risk of an outbreak in Canada was low. Doctors and scientists wrote to decision-makers with recommendations on how to prepare, but their advice was met largely with silence. This was especially the case in Ontario.

Ontario's Ministry of Health and Long-Term Care did not respond to questions about the proposal from infectious disease physicians, but the government is working on some changes.

The Globe obtained a copy of a presentation prepared by the ministry this month that borrows some language from the doctors' plan – such as "hub and spoke" model – but offers a more fragmented structure, without clear accountability resting with hospital experts. The

ministry's timelines extend into mid-October, and the presentation doesn't include specifics on new hires, but emphasizes the need to leverage existing expertise.

This is what happened during the first wave. In the spring, as the novel coronavirus ripped through long-term care homes, infecting staff and leading to the deaths of more than 1,800 residents in Ontario, the government turned to hospitals for help. Major hospitals have dedicated infectious disease specialists, who are responsible for preventing and dealing with outbreaks in their institutions. In April, teams of hospital experts were deployed to facilities in crisis.

The doctors showed up with supplies, such as masks, gloves, gowns and proper signage. Some of the homes hadn't even been marking which patient rooms housed a confirmed or suspected COVID-19 case. Basic infection control practices – such as changing gloves and gowns between patients – were not being followed. The hospital experts conducted safety audits, put better protocols in place, conducted training and helped with patients.

The recent proposal addresses this period in its infection prevention and control or IPAC plan: "In our experience, the majority of [these facilities] had significant deficiencies in IPAC practices and lacked IPAC expertise and accountability."

This is why a long-term solution is necessary, because hospitals don't have the bandwidth to provide that type of support in a second-wave scenario, doctors say.

Kevin Katz, who is in charge of infection prevention and control at North York General Hospital in Toronto and contributed to the proposal, said COVID-19 exposed the flaws in long-term care's infection control practices in the same way that SARS revealed shortcomings in hospitals. In 2003, Toronto hospitals were a major driver of SARS infections. Of those who became sick, about 40 per cent were health care workers.

"The silver lining of SARS-1 ... was that infection prevention and control in Ontario hospitals became a priority. ... We're now leaders internationally," said Dr. Katz. "COVID-19 could be that for long-term care."

The sector hopes so, too.

The Ontario Long Term Care Association submitted its own proposal to government in June, requesting funding for an in-house infection control manager in each home, plus money for staff training. Each home would also have an agreement with a partner hospital, so the manager could seek advice from an infectious diseases physician if needed.

It's a similar model to the one being used at Baycrest Health Sciences in Toronto. Scott Ovenden, executive vice-president of clinical programs, said his facility has a three-person infection control team as well as a contract with Mount Sinai Hospital, also in Toronto.

If Baycrest encounters a problem that needs additional expertise, his staff can reach out to Jennie Johnstone, Mount Sinai's medical director of infection prevention and control. Since the pandemic began, Baycrest has had just eight cases of COVID in its entire organization, which includes a hospital, long-term care home and assisted-living facility, Mr. Ovenden said.

But even this much more modest proposal has not been implemented.

On Sept. 11, deputy minister of long-term care Richard Steele sent a memo to key stakeholders in the sector. He promised that something would be coming, but put the onus on facilities to make it work: "I would like to take this opportunity to remind you of your responsibilities pertaining to ensuring a safe and secure environment for your residents."

Both the long-term care sector and doctors' proposals called for dedicated teams of specialists, but the latter's plan is designed to more closely mirror what happens in hospitals.

The doctors' proposal, which focuses on Toronto but is positioned as a potential model for the rest of the province, estimates that it would cost between $5.5-million and $7.2-million a year. That amount would cover the salaries of the more than 40 staff that would be hired. According to multiple officials involved in the discussions about the IPAC plan, the price tag of the program has been the primary stumbling block.

"It's shocking to me. [Long-term care and nursing homes] are where 80 per cent of the mortality has occurred. … In the grand scheme of things, this is not very resource-rich or hard to fund," said another IPAC specialist who consulted on the report. This individual, who provided The Globe with the proposal, is not being named as they feared ramifications from their hospital.

John Scotland, the chief executive officer at S&R Nursing Homes in Southwestern Ontario, said even though the sector is pushing for more resources, long-term care facilities are much better equipped to tackle a second wave than they were in March. Lessons were learned during those first few months. For example, they now have a six-month supply of protective equipment and widespread testing for his staff is available.

That said, he continued, the sector recognized it needs help – "ideally ... a dedicated team – not just to come in and do assessments, but to provide continuous training and auditing the

process."

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